Webinar 5 Issue Brief:
Leadership and Talent for Population Health Management

October 6, 2015
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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 fifth Issue Brief and associated webinar. This module addresses the new demands on leadership and talent as it relates to PHM. Other modules address a framework for the pursuit of PHM, business imperatives, clinical imperatives and technology needs.

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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“Governance and executive teams of California’s hospitals and health systems must have the knowledge and skills needed to succeed under the rapidly emerging value-based PHM model, which spans business and clinical domains.”

Anne McLeod
Senior Vice President, Health Policy and Innovation
California Hospital Association
Webinar 5 Issue Brief:
Leadership and Talent for Population Health Management

Introduction
Hospitals and health systems of the future will have a fundamentally different role. To meet and sustain population health management (PHM) goals of better care access, quality and outcomes at lower costs across a coordinated care continuum, organizations will need strong capabilities in nine areas. As described in the Webinar 1 Issue Brief, these areas include:

- Network strength
- Clinical integration
- Operational efficiency
- Consumer engagement
- Clinical care management
- Clinical and business intelligence
- Financial strength
- Purchaser relationships
- Leadership and governance

Inarguably, the most important of these competencies is the ability of executive leadership and governance to drive an organization’s clinical, operational and strategic success in a changing environment.

Effective and efficient PHM demands of U.S. hospitals and health systems higher levels of leadership, talent and organizational sophistication than perhaps ever before called for in health care. Governance and executive teams of California’s hospitals and health systems must have the knowledge and skills needed to succeed under the rapidly emerging value-based PHM model, which spans business and clinical domains. Clinician leadership — specifically from physicians, nurses, pharmacists and others as represented in executive management, boards of directors, and multidisciplinary care redesign and management teams — will be vital to success going forward.

The purpose of this five-part population health management program is to provide participants with an understanding of the critical components of PHM. Previous Issue Briefs described the six PHM business imperatives (Issue Brief 2), three clinical imperatives (Issue Brief 3) and the technology that supports a high-functioning care management platform (Issue Brief 4).
This Issue Brief builds on the preceding material. It focuses on the leadership and competencies that make it possible for organizations to achieve PHM imperatives (Figure 1). Achieving these imperatives yields effective health and health care interventions along the risk continuum for patient populations served by provider organizations.

Specifically, this Issue Brief:

- Defines attributes of the PHM leadership and governance mindset
- Describes important perspectives on scale, volume and partnerships
- Identifies new leadership roles and competencies for important facets of PHM
- Examines issues of governance and management structure
- Considers changing metrics of leadership performance and accountability
- Provides two case examples of PHM leadership in California provider organizations
- Concludes with a call to action for the leadership of California’s hospitals and health systems

The case examples provided from California hospitals and health systems bring to life the leadership and governance challenges now faced by organizations as they evolve toward PHM, and offer lessons learned in the development and preservation of strong PHM leadership and talent.
A New Leadership Mindset

Leadership assumptions, methods and incentives for the sickness, hospital-centric model of health care have been in place in this country since the mid-1960s. They now are giving way to new approaches, behaviors and tools that are more appropriate for an “anywhere care”-centric model focused on population health, and disease prevention and management.

A new leadership mindset with four basic attributes will spur progress toward PHM: a new view of health care, agility, innovativeness and commitment to planning. A description of each follows.

Attribute 1: Committed to a New View of Health Care

Hospital leaders with the new mindset recognize that change is not coming to health care; it’s already here based on consumer-driven, economic and Internet-fueled health care choice. They understand that if consumers want telehealth, they will get telehealth. If consumers prefer the convenience and style of nurse practitioners in retail store-based clinics, they will get nurse practitioners in retail settings. Consumers are bypassing expensive, inconveniently located facilities and prefer to access care in places close to where they live, shop and work.

Defending the long-standing activity-based business model is not a long-term strategy. Inevitably, consumers will gravitate toward the more desirable products and services offered by innovators. Trying to stand in the way of this economic movement is like standing in the way of Apple, Facebook or Amazon; it just can’t be done.

As the value-based model replaces the volume-based model, hospitals will see their financial and clinical strength — and likely their market share — challenged as new competitors attracted by the new business model disrupt the delivery system in local markets.

Significant changes are needed for hospitals to operate under this model. Boards and executives must commit to a new view of health care’s future by accepting the misaligned incentives of the traditional fee-for-service (FFS) model and embracing a fundamentally different role under PHM.

Proactive leaders are willing to revisit organizational purpose in the face of a changing socioeconomic and business landscape. The new view of purpose entails accepting that hospitals are not assured a position as the controlling hub of health care delivery in their communities. That role could be played by a powerful non-hospital entity that builds a system to provide products and services in an affordable and accessible way.

Leaders of legacy entities best serve their communities’ interests by dedicating their available energy, talent and capital to being part of health care’s reinvention. With their wealth of knowledge, broad infrastructure and, in many cases, financial wherewithal, existing health care provider organizations are well positioned to collaborate with partners that bring other attributes — such as new technology, community-based solutions and nimble structure — to the challenge of transforming the large, complex health care system.

Health care is beginning to see examples of this kind of collaboration. For example, HealthSpot is working with Cleveland Clinic, Kaiser Permanente and other health systems to incorporate its virtual walk-in kiosks in non-health care settings. Blue Cross & Blue Shield of Illinois shares information

“Hospital leaders with the new mindset recognize that change is not coming to health care; it’s already here based on consumer-driven, economic and Internet-fueled health care choice.”
with DuPage Medical Group so that its independent practice physicians know the cost and quality of services DuPage Medical patients receive when they get care outside of the Group.\(^7\) Led by San Antonio Regional Hospital, Partners for Better Health and the County of San Bernardino Department of Public Health, the Healthy Ontario Initiative of Ontario, Calif., is improving access to healthy, affordable food and safe places for community residents to be active to reduce high rates of obesity and obesity-related diseases.\(^8\)

Hospitals can choose to begin pivoting to the new business model, in essence disrupting themselves. The board and executive team should evaluate whether they are capable of reorganizing and achieving financial and clinical relevance in an ambulatory and telehealth-focused delivery system.\(^9\) This path holds the opportunity to maintain relevance and market share — and, therefore, financial and clinical strength — in the changing market. A wholehearted commitment to this view of health care is required going forward for all parties providing services through the organization, including affiliated physicians, home care and behavioral care agencies, and post-acute facilities.

**Attribute 2: Agile**

The role of health care’s leaders now centers on building organizational agility, which is defined as the ability to nimbly operate current business while simultaneously preparing for changing/new conditions.\(^10\)

Today’s successful leaders have to be both transformers — by moving health care to a PHM-based model — and business curators — by managing the traditional business while health care in their community(ies) transitions to the new model.

For legacy organizations, the transition to a different model is incredibly complex. To improve access, outcomes, costs and quality — all at a price point that is affordable for the population — executives and boards will need to make difficult decisions about the direction, pace and timing of change. Some core elements of the organization’s structure, talent, technology and operations likely will have to change, as described in later sections.

Agile leaders recognize the value of collaboration with all stakeholders — internally and externally — who are willing to contribute energy and new ideas. Sharing one’s “perceived power” with others is a critical aspect. Working with the best ideas, agile leaders will formulate a new vision of their organizations’ future, and through teamwork, will do the hard work needed to make the transformation.

**Attribute 3: Willing to Experiment and Innovate, Understanding the “Drumbeat” for Value**

The drumbeat for value has been present in health care for decades and is growing considerably faster and louder.\(^11\) Adoption or expectation of adoption of value-based payment has increased rapidly as evidenced by the following:

- The percentage of hospitals that expect more than 50 percent of their revenue to be tied to value-based payment within the next two years tripled from 7 percent to 22 percent within a six-month period, according to a recent Kaufman Hall survey.\(^12\)

“Working with the best ideas, agile leaders will formulate a new vision of their organizations’ future, and through teamwork, will do the hard work needed to make the transformation.”
• In January 2015, the Centers for Medicare & Medicaid Services (CMS) announced its goal of moving at least 50 percent of its payments into value-based mechanisms by 2018. Just two days later, a task force of influential providers and payers announced their goal of moving 75 percent of their business under value-based payment by 2020.

Unlike the “tipping point” described by Malcolm Gladwell, which happens quickly and is hard to prepare for because predictions are lacking, health care organizations have had ample forewarning of the basic trajectory of health system change.

The concepts of value-based care first found policy expression in the Health Maintenance Organization (HMO) Act of 1973 and proliferated in the late 1980s in the form of managed care and capitation. Implementation problems and adverse public opinion led them to fall from favor in some areas, but the idea of linking payment incentives to care management never went away. Many insurance plan designs, payment methods and delivery models use such linking. In addition to California, many regions of the country have made significant strides in managing quality and cost by coupling value-oriented payment with advanced care management.

California is at the forefront of this transformation by virtue of its early development and current prevalence of HMOs. But change is playing out in each market in complex ways, and the way each provider organization can and should respond also is complex.

Organizations that use value-based payment and delivery models now, even on a limited scale as pilot tests, are better positioned for success as the delivery system continues its progress toward broad implementation of value-based care. The approach of asking “Where has X been implemented successfully?” and then replicating what other organizations have done may or may not be appropriate in specific service areas. Prototypes likely require customization.

Proactive hospital and health system leaders are innovating, looking within and beyond health care for models that work. Without undermining existing business, they are funding experiments until such experiments reveal a viable direction for the organization or not. These leaders understand that some experiments will fail and that failure is an integral part of innovation, creativity and the journey to value. If an experiment fails, funding flows to other experiments.

For example, in 2012, Houston-based MD Anderson Cancer Center launched an ambitious plan to dramatically reduce mortality for seven types of cancer through cancer control and prevention. Called the Moon Shots Program, the initiative involves multiple disciplines in a carefully orchestrated, multi-year effort inspired by President Kennedy’s 1962 challenge to America to reach the moon within the decade.

The program’s core qualities do not depend on size or funding, but on a mindset orientation focused on the health of a population. The goals are to identify a population segment in need of preventive efforts, target environmental and behavioral factors contributing to health problems in that segment, and work with stakeholders to mitigate those factors.

For example, one early success involved reducing the use of tanning beds. Cancer center researchers found an 85 percent increase in melanoma risk for people who started indoor tanning before age 18. MD Anderson staff conducted numerous initiatives aimed to educate Texas lawmakers about this risk. As a result, the state raised the minimum age for use of tanning beds to 18. MD Anderson also has tackled the sensitive matter of HPV vaccination and has formed a partnership with health care organizations in 18 states to increase HPV vaccination rates.

This prevention perspective is new to MD Anderson and perhaps to most traditional provider organizations, but it is critical to fulfilling the mission of improving community health. The Moon Shots Program demonstrates a focus and orientation toward solutions by coupling an ambitious goal with highly pragmatic execution. Actions are carefully chosen. The effort is geared toward measurable accomplishments. Results are tracked and publicized.
Ultimately, the Moon Shots Program suggests a new way for hospitals and health systems to think about mission. Not content to limit itself to treating cancer, or even to discovering ways to mitigate cancer through its research, MD Anderson has stepped outside its walls and into its community and beyond to help stop cancer before it starts.

Thinking outside the box is advantageous in today’s health care leadership environment. “We all have challenges we want to solve or products to create, but if you’re dependent on a core team of five innovation experts or your hospital staff, you’re limiting your ability to do such things,” says Peter H. Diamandis, MD, President and CEO of the X PRIZE Foundation. “Non-experts can take a look at solving a problem with different eyes, sometimes coming up with a very unusual approach. Ultimately, the day before something is truly a breakthrough, it’s a crazy idea.” The creative methods used by Thomas Edison (see below) can be helpful for health care.

Every hospital should have a moon shot. What’s yours?

Innovation at its Best: Thomas Edison’s Way of Working

Characteristics attributed to Thomas Edison’s way of working have parallels to what health care is seeking today:

- In formulating problem-solving ideas, Edison was inventing; in developing inventions, his approach was akin to engineering; and in looking after financing and manufacturing, and other post-invention and development activities, he was innovating.
- Edison worked by conceiving an idea and working toward achieving it; he adroitly chose problems that made use of what he already knew.
- Edison invented by repeatedly trying devices in more complex environments to progressively approximate their final use conditions.
- Edison’s method was to invent systems rather than components of systems; he did not just invent a light bulb, but an economically viable system of lighting, including its generators, cables, metering and more.
- Edison blended invention with economics. His electric lighting system was designed to be an economic competitor with gas lighting.
- Edison assembled and organized the resources that would lead to successful inventions: individuals with skills that would aid the task; equipment – machines, instruments, chemicals, etc.; and literature on the subject (he started a project with a thorough literature review).
- Edison was a charismatic leader who drew on the ideas of those who worked with him.
- Edison was obsessive in his pursuit of outcomes and did not allow things like cost or lack of sleep to deter him.
- Contrary to common opinion, Edison made use of the scientific method, but in a way that was limited to the task at hand and did not seek to develop generalized theories.
- A key to Edison’s intellectual approach was to always doubt and never take things for granted.
- Edison had a significant ability to grasp quantitative relationships despite his limited mathematical training.
- Edison was very effective at sketching, which enabled him to conceive and manipulate his ideas on paper.
- Edison did use “hunt and try” extensively, but only when no theory existed and in a systematic rather than random manner.
- Edison was distinguished by his ability to deal with complex change.

Attribute 4: Uses Integrated Planning and a Blueprint for the PHM Journey

Managing in an environment of complex change requires that executives be able to analyze many market dimensions and develop and plan for multiple scenarios. They then must move ahead to make the fundamental changes needed in their organization’s technology, system configuration, and clinical and business processes. The board should be involved in, or provide close oversight of, relevant analyses and planning exercises.

Revisioning and redesigning an organization’s delivery system should be staged based on the entity’s unique market, capabilities, desired role and competitive factors. Leadership must ensure that the foundational planning process is grounded in fact-based market, financial and clinical/quality realities, and the organization’s current and expected performance related to these realities. Certain organizations will be able to carve out a strategy to deliver only high-end acute-care services. But for most hospitals and health systems, an effective ambulatory and virtual strategy will be key to market relevance.

Leaders with the new mindset are committed to use of a strategic planning process and plan. The plan positions the organization to provide services in an environment characterized by better informed and more cost-conscious consumers. It identifies the pieces of infrastructure required for a delivery system that firmly positions the organization in the ambulatory-centric sphere, and with a blueprint-like approach, determines how and where those pieces would be assembled.

The existing hospital chassis is not likely to have the right assets in the right geographies to manage population health. The optimal delivery system for each organization will balance population size, access, resources, quality of care, cost per unit of service and competitive considerations.

A blueprint identifies the items to tackle first, but leaders ensure that all of the puzzle pieces are on the table so that the organization applies objective criteria to drive delivery decisions and their implementation. Required investments include the elements of a new and different chassis with the following elements:

- An enhanced outpatient network
- Technology for virtual interaction
- Employees with technological know-how to meet the changing needs of activated patients
- Intellectual capital in areas such as care redesign, payment/pricing models and community health

“Managing in an environment of complex change requires that executives be able to analyze many market dimensions and develop and plan for multiple scenarios.”
Leaders know that developing the PHM chassis takes time. Stakeholder behavior may not change or stabilize quickly. Early-stage investments often take five or more years to show positive return on investment. This means that leaders must continuously work to minimize overall enterprise risk as they invest capital and revise balance sheet strategies for a PHM-focused future (Figure 2).

The changing landscape will impact the reliability of credit platforms, the appropriate funding mechanisms, the investment of cash reserves and the ability to manage/support organizational risk. As described in the next section, new partnerships likely will be required to cover new services and/or geographies. Securing such arrangements may be complex, so leaders must be ready to give the exploration process the deserved time.

**FIGURE 2. The New Era of Capital Investments and the Impact on Risk**

<table>
<thead>
<tr>
<th>Composition of Capital Investments</th>
<th>Yesterday</th>
<th>Tomorrow</th>
<th>Change</th>
<th>Risk Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working Capital</td>
<td></td>
<td></td>
<td>No material change</td>
<td>Continue evoking cross-industry best practices</td>
</tr>
<tr>
<td>Equipment</td>
<td></td>
<td></td>
<td>Constant, though cyclical, and accelerates with technological advances</td>
<td>Retain cash flexibility; improve lease incurrence and management</td>
</tr>
<tr>
<td>Technology</td>
<td></td>
<td></td>
<td>Increases significantly with care coordination, consumerism, big data, etc.</td>
<td>Shorter funding horizons; different funding partners; greater cash allocation</td>
</tr>
<tr>
<td>Bricks and Mortar</td>
<td></td>
<td></td>
<td>Decrease following transition to ambulatory care delivery and reduced utilization</td>
<td>Reduced access to “low, long and level” tax-exempt capital and risk structures</td>
</tr>
<tr>
<td>Risk Reserves</td>
<td></td>
<td></td>
<td>Significant increase in the amount and diversity of risk-based arrangements</td>
<td>Rebalancing of risk tolerance (overweight to operations)</td>
</tr>
<tr>
<td>Strategic Investment</td>
<td></td>
<td></td>
<td>Increases with changes to business model and core competencies</td>
<td>Potential need for rapid and significant allocation of capital capacity (including excess cash resources)</td>
</tr>
</tbody>
</table>

Note: For illustrative purposes only; excludes routine operating expenses

Source: Kaufman, Hall & Associates, LLC

“Leaders know that developing the PHM chassis takes time. Stakeholder behavior may not change or stabilize quickly. Early-stage investments often take five or more years to show positive return on investment.”
Contemporary Leadership Perspectives on Scale, Volume and Partnerships

Leadership perspectives on scale, volume and partnerships will drive the strategic initiatives pursued for PHM. A description of each follows.

**Importance of Scale**

For continued success, a significant number of organizations may need to become bigger entities, or become part of a bigger organization. Leaders committed to PHM understand the importance of size or scale created by the following trends:

- Revenues will be under significant pressure over the next years
- Business as usual will no longer work; the key challenge will be learning to manage population health effectively and efficiently
- Many organizations will attempt to position themselves closer to the premium dollar
- Core PHM competencies will need to evolve
- Large investments in IT and care management will be essential

Significant intellectual and financial capital will be required to succeed, as well as absorb and manage risk. The required scale depends on the size and nature of the relevant providers, payers and employers in the area.

Scale already is bringing financial benefits in an FFS world. Analysis of rating agency data\(^p\) indicates that, in general, hospital systems with more than $1 billion in revenue have experienced higher revenue growth, better balance sheet ratios, and higher operating and operating cash flow margins than smaller health systems. Margins have been higher by one or two percentage points. While this difference may seem minor, it allows large organizations to invest 25 or 30 percent more each year in critical areas.

Additionally, the benefits of scale increase as revenue grows beyond $1 billion. Systems with more than $4 billion in revenue generate five times as much cash as those with revenue between $1 billion and $2 billion.

Scale can help ensure a smoother transition to the new business model by helping providers play “catch up” on the ambulatory front, and enabling them to invest capital in IT, care delivery redesign, physician network development, and other infrastructure and expertise needed to manage care for a fixed price under PHM models. Not every organization will be big or part of a big system. There will be opportunities for smaller organizations to participate meaningfully in PHM by working within a network to provide specified services for covered populations managed by larger organizations, as described in the Webinar 1 Issue Brief.

“Not every organization will be big or part of a big system. There will be opportunities for smaller organizations to participate meaningfully in PHM by working within a network to provide specified services for covered populations managed by larger organizations.”
The New View of Volume

Leaders are shifting their view of volume in order to build “market share” of the covered populations. In the FFS world, volume for hospitals and health systems was defined by the number of discrete services provided to patients, with more services being better for providers because payers provided revenue based on services delivered to insured patients.

In the PHM world, volume is not the number of services provided, but the number of individuals covered under risk- or value-based contracting arrangements that pay a fixed revenue per managed or attributed lives. Also important are influenced lives, which are those referred by physicians, and incidental lives, or those patients who self-refer (Figure 3).

**FIGURE 3. The New View of Volume**

Managed/Attributed Lives
- Fixed revenue per person or “member” (PMPM)
- Organized under patient-centered medical homes and ACO-like models
- Organization receives portion of revenue depending on which risk management and care delivery services it provides through its assets and relationships

Influenced Lives
- Contractual relationships with payers, employers and providers
- Preferred provider status for select tertiary/quaternary services and carve-out exceptions

Incidental Volume
- Non-strategic volume such as emergency department, cash customers and patient preference decisions

“**In the PHM world, volume is not the number of services provided, but the number of individuals covered under risk- or value-based contracting arrangements that pay a fixed revenue per managed or attributed lives.”**
Health systems and plans with more covered lives currently have stronger performance, which could be attributed to:

- Attaining a level of population coverage that limits operating performance variability under risk-based reimbursement models
- Sustaining growth in the face of declining health care utilization levels
- High relevance to purchasers (employers, insurers, patients) by offering the right mix of services and locations at the right cost, thereby offering one-stop shopping

Figure 4 illustrates the relationship between operating margin and the number of lives an organization covers. As covered lives increase, operating margin becomes more consistent and positive.

**Figure 4. The Impact of Scale on Operating Performance Variability**

<table>
<thead>
<tr>
<th>Health Plan Scale: Covered Lives</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-50K</td>
</tr>
<tr>
<td>50-100K</td>
</tr>
<tr>
<td>100-250K</td>
</tr>
<tr>
<td>250-500K</td>
</tr>
<tr>
<td>500K-1M</td>
</tr>
<tr>
<td>1M+</td>
</tr>
</tbody>
</table>

Full-Risk Health Plan Operating Margin

-20% -15% -10% -5% 0% 5% 10% 15%

**Note:** This graphic indicates that entities with greater than 250,000 covered lives achieve lower variability in operating margin performance, with average performance consistently of 1-3 percent.

Source: Kaufman Hall analysis; Citi Research 2011, Commercial Risk Analysis: “A Good Lawyer Knows the Law. A Great Lawyer Knows the Judge.”

**Partnerships Required**

PHM, at its core, involves integration across the health/care delivery system, most often achieved through collaborative partnerships. As defined in the Webinar 1 Issue Brief (page 3), “population health management occurs when a health care system or network of providers works in a coordinated manner to improve the overall health, health outcomes and well-being of patients across all defined care settings under risk-bearing arrangements.”

Most hospitals and health systems will find it prohibitively expensive to develop their capabilities to manage population health across the full care continuum; they will need to establish collaborative partnerships and affiliations.

Leaders will have to decide with whom to contract and partner and under what terms. Potential strategic partners could include health plans, health systems, employers, management services organizations, health IT companies, community organizations, and other types of traditional and
nontraditional service entities. Specific consideration of partnerships with community-based organizations may be particularly important in many regions due to the significant impact to PHM of socioeconomic factors, such as poverty, homelessness, substance abuse and lack of access.

As mentioned in the Webinar 1 Issue Brief, the degree of integration desired by partnering organizations has a broad spectrum, ranging from low (leveraging existing arrangements or developing new collaboratives) to high (full sale to partner). Such arrangements as joint ventures, minority interest joint ventures and 50/50 partnerships lie in between.

As PHM-based value arrangements reshape utilization, leaders of most hospitals and health systems will seek partnerships that enable them to grow their attributed or accessible managed populations to support organizational infrastructure and associated costs. Expected clinical improvements and business efficiencies must be achieved post-merger or post-partnering; otherwise bigger may not be better.

As mentioned in the Webinar 4 Issue Brief, hospitals and health systems typically partner to build health information exchange (HIE) for PHM-focused care management platforms. But their leaders must define and understand what they are trying to accomplish before entering a partnership. Clinical integration and PHM require “heavy lifting,” integrating people, process, information, technology and change. The complexity of the work must be recognized and addressed by leadership teams.

Emerging Roles and Competencies for Management and Governance

In most organizations, executive management and/or board skill sets required to effectively guide the hospital or health system through the transformation to PHM are being, or will need to be, secured or strengthened. The core leadership skill set will consist of those competencies that will enable board members and senior executives to move their organizations into the desired PHM role and position, as defined by leadership.

The skill set will differ by organization, but is likely to include at least the following six areas of expertise:

- Ability to attract and retain clinician leadership
- Network development and management
- PHM and its associated risk
- Clinical, business and consumer/patient intelligence
- Innovation and transformation
- Technology

A description of each follows.

“Most hospitals and health systems will find it prohibitively expensive to develop their capabilities to manage population health across the full care continuum; they will need to establish collaborative partnerships and affiliations.”
Ability to Attract and Retain Clinician Leadership

PHM will not be possible without physicians, nurses, pharmacists and other clinician leaders who drive the design/redesign of clinical care delivery.

In the traditional management and governance model, clinician representation in executive leadership roles and key positions on board committees typically has been limited. In the PHM world, both boards and executive teams must have first-rate clinician leaders who have autonomy and authority. Significant clinician participation in decision making at all levels will be required, particularly by physician and nurse leaders.

According to The Governance Institute, 21% of responding hospitals and health systems added physicians to the management team, and nearly 10% added physicians to the board during the past two years. Only about 3% added board members with expertise in PHM, although 89% of organizations are making changes of some kind to prepare for population health. Seventy-two percent of responding organizations have zero voting nurses on the board, and the average percentage of nurses on the board is only 3% overall. Diana L. Smalley, FACHE, Regional President of Mercy in Oklahoma, urges this:

“Nurses need a voice at the leadership and governance levels now more than ever before in our industry. To that end, nurse executive participation in board meetings should not mean that he or she sits in the back of the room and listens to meeting discussions. Participation should mean that he or she establishes a relationship with the board that results in being viewed as a respected member of the executive team, whose opinions are valued and actively sought on relevant issues (ideally, as a voting or non-voting member of the board).”

Approximately 5% of hospital leaders currently are physicians, but that number is expected to increase as health care moves to a value-based system. Enabling physicians and other clinicians to take ownership of the clinical enterprise likely will involve assisting them in developing new skill sets. A strategy/program to develop clinician leaders is recommended.

A survey of physicians taking a “Physician Executive Boot Camp” indicates that a majority lack formal training and that new physician leaders typically were not planning on an executive career. Clear expectations about the new role generally were not available, nor were measures of success, plans for continued growth and development, and financial or other resources. Additionally, few new physician leaders, if any, had a mentor.

“In the PHM world, both boards and executive teams must have first-rate clinician leaders who have autonomy and authority.”
Leaders should ensure that all of these elements are in place. Making the transition from a clinician to a physician leader involves new skills, including quality measurement and improvement, cost-management, personnel management, practice workflow improvement, data analysis, change management and communication (see below).

Clinician leadership development programs are now widely offered. Some are degree programs available through universities, associations and other entities; others are certificate programs through academies that present hundreds of courses for qualified physicians, nurses and other clinicians; still others are programs developed by health systems for their clinicians.

Physician Competencies: From Top Doctor to Physician Leader

The competencies that make an individual a good physician are not the same as those that make a physician a great leader. However, the heart of being a good physician leader is being a good physician.

Physician Core Competencies

- Medical knowledge: Exhibit proficient knowledge of biomedical, clinical and cognate sciences and application of patient care.
- Patient care: Provide compassionate, appropriate, effective patient care.
- Practice-based learning and improvement: Continually assess and evaluate patient care practices and assess and assimilate scientific evidence.
- Professionalism: Demonstrate a commitment to carry out responsibilities. Adhere to ethical principles. Be sensitive to a diverse patient population.
- Interpersonal and communication skills: Demonstrate skills that result in effective communication exchange. Work effectively with other members of the health care team.
- Use of informatics: Use informatics to enhance patient care delivery.

Next-Generation Core Competencies

In addition to the standard physician core competencies, physicians need to develop and enhance the following skills to be effective leaders as the health care delivery system transformation continues.

- Systems theory and analysis: Identify ways to improve the quality and safety of patient care through greater care coordination and process improvement.
- Use of information technology: Effectively use information technology to improve the quality and safety of patient care.
- Cross-disciplinary training and multidisciplinary teams: Understand and respect the skills of other practitioners.
- Expanded knowledge: Develop greater understanding of population health management, palliative and end-of-life care, resource management and medical economics, and health policy and regulation.
- Interpersonal and communication skills: Further enhance interpersonal and communication skills to become a true member of the team. Demonstrate empathy and understanding of cultural and economic diversity. Practice excellent customer service. Improve time management. Enhance conflict management skills and provide effective performance feedback. Improve emotional intelligence, self-awareness and relationship management.

**Network Development and Management Skills**

Because most organizations will be part of networks, their leaders must be able to shape or join such networks through making active or even preemptive arrangements with other providers. For organizations that are building capabilities to manage care across the full continuum, leaders with skills to manage non-hospital businesses — such as home health, hospice, labs, skilled nursing, long-term care and other non-acute care businesses — must be in position.

Network development expertise is potentially a weak area for many health care leaders. Although leadership teams and boards typically have been very good at aggregating hospitals, and in some cases physicians, few leaders have expertise in developing the full complement of entities required to support a population's health, particularly post-acute providers.

Network development and participation require relationship-building skills. Leaders must have expertise in securing and maintaining partnerships in portions of the care continuum that are not owned directly by the organization. Needed skills include contract negotiation, quality and service performance monitoring and management, information technology interface and other capabilities that are currently highly underdeveloped in most hospital organizations. In some markets, this expertise may be critical to an organization's competitive position.

A new role emerging in some organizations is titled similarly to Chief Operating Officer for Network Development and Management. This individual is responsible for shaping, joining and managing networks, and securing and maintaining partnerships in non-owned portions of the care continuum.

Management expertise with physician networks, which is a very different activity than managing acute hospital operations, also likely is required.

Other senior executive roles are emerging in areas such as product and benefit design, health care economics, managed care pricing, and health plan and managed care plan contracting.

**Expertise with Population Health Management and Its Associated Risk**

Population health management is an entirely different model of care delivery than episode-based care. David B. Nash, MD, Dean of the Jefferson School of Population Health, indicates that providing care for patients along a continuum — from preventive care through post-acute care — requires leadership expertise in:

- Understanding specific patient populations
- Changing the culture of practicing medicine to a team-based approach
- Creating interdisciplinary teams to provide coordinated care to patient groups
- Getting physicians on board through effective incentive programs

Chief Population Health Officer is a new role emerging in some organizations. This individual typically has responsibility for the overall strategic direction and coordination of population health and care management initiatives organization-wide. He or she is usually a physician or nurse, often with public health and team-based care experience, and an advanced degree in business or health administration.

The Chief Population Health Officer ensures that the organization comes to an agreed-upon definition of population health and wellness in target markets, and then moves the organization vigorously forward to provide relevant services in appropriate settings.
The executive team and board also must have leaders who have expertise in assessing, managing and mitigating risk assumed by the organization under population health-based contracts with employers, and public and commercial payers. During the 1990s, many hospitals and health systems experimented with assuming risk under capitated arrangements. But because they were unable to accurately model utilization and costs for serving a particular population, most of these organizations experienced significant losses related to underestimated expenses and higher-than-projected volume.

For many hospitals and health systems, management of population health contracts that have both upside and downside potential will be a new venture that requires actuarial and/or insurance expertise to be resident in the organization or purchased from external parties.

The board and executive team must understand risk in its totality. Assuming actuarial risk as an accountable care organization (ACO) or some other type of population health model will increase the organization’s total financial risk. This is due, among other things, to the high level of capital investment required to build the physician and technology infrastructure, and the large reserves required for risk contracts. New roles on executive teams and boards likely include actuarial services and predictive/risk modeling.

**Expertise in Clinical, Business and Consumer/Patient Intelligence**

Hospitals and health systems will need leadership competency in collecting, analyzing and using clinical, business and patient/consumer data. These data will be critical to setting appropriate goals and intervention targets for population health initiatives and to the evaluation of executive performance related to meeting such goals.

Key considerations include ensuring appropriate resources (financial and talent) for clinical and administrative tools, ongoing data collection and management, data analytics, and the integration of findings with organizational plans and care delivery.

In some organizations, C-suite roles are emerging for a Chief Experience Officer or Chief Patient Engagement Officer:28 “The ability to connect the organization to the customer experience and touch points in real time has deep implications for the organization of the future,” comments management advisor Ram Charan. “It speeds decision making and allows leaders to flatten the organization, in some cases cutting organizational layers by half.”29

In addition to having responsibility for the overall user experience, the Chief Experience Officer may oversee marketing communications; community, internal, human resource and investor relations; and other interactions between the organization and its various audiences. Other senior executive roles are emerging in such areas as consumer solutions and advanced analytics, among others.

**Innovation and Transformation Expertise**

As previously described, innovation and transformational change management will be part of the new leadership mindset. New roles on the management team tied to these PHM capabilities are Chief Innovation Officer and/or a Chief Transformation Officer.

A Chief Innovation Officer has responsibility for cultivating new ideas within and bringing new ideas to the organization, working with the management team to implement initiatives, engaging front-line staff to identify and remove barriers to change, and tracking and communicating performance metrics and results. It is not unusual for organizations to look for candidates from digital or e-commerce businesses who are creative, outside-the-box thinkers.

Many organizations are establishing structures for developing innovation initiatives, including innovation labs for testing new ideas and creating councils on clinical innovation. With oversight from the Chief Innovation Officer, these councils are charged with identifying, and perhaps implementing, service delivery improvement opportunities.
A Chief (Clinical) Transformation Officer leads the organization's transformation initiatives and typically has responsibility for transformational change management at the operational/clinical level. This individual often has clinical credentials (physician or nurse) and can help other clinicians move from clinical to management positions.

**Expertise Related to Technology**

New technologies are rapidly emerging in ways that will be clinically and competitively disruptive for organizations, but will improve health outcomes for patients and reduce health care costs for the nation. Boards and management teams must stay abreast of technologies and understand the implications. Leadership also should ensure the analytics and technology vehicles appropriate to the organizations’ strategic and financial goals.

Hospitals will need to be much more diligent in building and maintaining their technology-enabled care management platform, as described in the Webinar 4 Issue Brief. Depth and breadth of health/clinical IT expertise will be required in leadership positions. Considerable depth of expertise is needed to understand clinical and management systems. Complex and capital-intensive, these systems can help, slow or hurt the organization in reaching its strategic objectives.

Some organizations establish a new role of Chief Health Information Officer or Chief Medical Informatics Officer. Different than the traditional Chief Information Officer or Chief Medical Information Officer role, this individual:

- Leverages the organization's investment in clinical, financial, care management and patient engagement systems to drive value creation
- Partners with other executives to design, develop and execute strategies for digital health care
- Collaborates with other members of the C-suite and senior executive team to lead the convergence of quality, informatics and analytics in a way that aligns IT strategy and overall organizational direction

This person thinks systematically about the health system as a whole, rather than its specific components, notes Pam W. Arlotto, President and CEO of Maestro Strategies. He or she is leading change through people, process and the use of information rather than technology adoption and implementation. The broader focus is critical.

**Organizational Structure for PHM Governance and Leadership**

Beyond new roles and competencies for leadership, organizational structures within which individuals work also must be examined. Over time, many health systems have evolved into multifaceted “conglomerates,” whose governance and organizational structures have increased the cumbersome nature of making the changes that will be required for the future.

Organizational structures likely will need to be reconfigured in a way that will enable leaders to be nimble in response to opportunities, threats and a fundamentally different role with population health in their communities.

“**Organizational structures likely will need to be reconfigured in a way that will enable leaders to be nimble in response to opportunities, threats and a fundamentally different role with population health in their communities.**”
From Hospital-Centric to System-Centric

With PHM-focused care delivery, hospitals and health systems will move away from hospital- and site-centric structures to service- and system-centric organizational models. This represents a radical departure from the way most hospitals and health systems are structured today with the leadership nexus centered at the individual hospital level.

In an era of PHM, the desired structure for an organization is likely to be one that maximizes the functioning of the system or organization as a whole. Some organizations may need to evolve from a holding company model — under which system leadership and governance typically are not involved in day-to-day operations of the subsidiary hospitals — to an operating company model, which involves a high degree of centralized authority from the parent system. This switch could better maximize the organization’s strategic business objectives (see page 21 for definitions).

A sample, simplified organizational chart for a service-centric health system appeared in the Webinar 2 Issue Brief (page 21). This structure is consistent with a PHM model, which reduces the barriers to the integration of services and cost-structure management across the organization.

Figure 5 illustrates how the PHM division of a large Population Health Manager, which operates three networks across a broad geographic area, might be structured. At the top, the PHM division’s governance and executive leadership are integrated within the broader parent company. The PHM operations for the managed networks are centralized, including: care model coordination and integration; value-based and risk contracting and products; service delivery and network operations; analytics and information systems; financial risk management and modeling; and innovation, training and education. Centralization provides oversight of decisions related to build, buy or partner options for current and future networks. The three local PHM networks serve as delivery hubs for specific populations and work with physician organizations for primary care, and other providers to serve the defined care needs of specific populations.

**Figure 5. Sample Organizational Structure for PHM**
Figure 6 illustrates how a new PHM company, created through the equity-based partnership of two or more entities, might be structured. At the top, a Board of Managers with proportionate representation of the two entities provides oversight of a PHM “NewCo” or new company. Functional areas include:

- **Care coordination:** Develops care coordination model that targets highest-risk patients; aligns care coordination efforts of member organizations to build toward centralized function; collaborates with physicians to identify areas of opportunity; and develops strategy for quality initiatives

- **Managed care contracting:** Seeks out value-based opportunities; identifies financial implications of new value-based contracts; develops and executes negotiation strategy with payers; coordinates with providers to make sure contract terms are met; and works with providers to develop incentive model

- **Network development and provider engagement:** Identifies appropriate network size for risk contracts; establishes physician recruitment targets; cultivates relationships across the continuum (i.e., post-acute, physician groups); assesses requirements for non-physician providers; and establishes credentialing process

- **HIT/IT:** Develops clinical and business intelligence that analyzes and reports on clinical and financial data; has ability to attribute patients to providers to support incentive alignment; and develops quality, utilization and financial metrics to monitor and report on progress

Structure-related governance and leadership implications of new partnerships should be fully considered so that both parties meet their strategic and operational objectives. Leaders should be careful to ensure that a new organizational structure related to PHM does not recreate the bureaucracy and “silos” present in some traditional hospital-centric organizational structures today. These silos have limited communications by departmental boundaries and localized authority, making overall PHM efforts difficult at best.

**FIGURE 6. Structure of New PHM Company**

“Leaders should be careful to ensure that a new organizational structure related to PHM does not recreate the bureaucracy and ‘silos’ present in some traditional hospital-centric organizational structures today.”
Changing Metrics of Leadership Performance and Accountability

Leadership is responsible and accountable for hospital/health system performance; thus, the measures used for hospital performance must be reflected in the evaluation of leadership performance.

Health care boards have management oversight responsibilities, which include:

- Following a formal process for evaluating the CEO’s performance with mutually agreed-upon performance goals
- Having objective measures for the achievement of clinical improvement and/or patient safety goals as part of the CEO’s performance evaluation

The CEO should ensure that the rest of the executive team also has agreed-upon performance goals and objective measures related to operational initiatives, such as clinical and/or patient safety improvement, and clinical efficiencies, such as reducing unwarranted clinical variation. Fee-for-service metrics tied to utilization and other indicators will not be the critical metrics to watch going forward.

Key Definitions Related to Organizational and Governance Structure

**Organizational Structure:** The framework, typically hierarchical, within which an organization arranges its lines of authority and communications, and allocates rights and duties. Organizational structure determines the manner and extent to which roles, power and responsibilities are delegated, controlled, and coordinated, and how information flows between levels of management and up to the board. An organizational chart typically illustrates the organizational structure.

**Governance Structure:** The way in which a board and its committees are organized and populated to conduct the business and associated responsibilities of leading and overseeing the organization entrusted to its fiduciary care. Board size and composition, committees and committee meeting frequency, board meeting frequency and allocation of board meeting time all are fundamentally critical to overall board performance and governance structure.

**Holding Company Model:** A holding company (or holding “organization”) provides global oversight and direction for the organization and allocates resources and/or invests in other companies, commonly known as subsidiaries. Holding companies are usually not involved in day-to-day operations of the subsidiaries, but establish broad strategic and policy parameters that guide the operations of both the parent and subsidiary organizations. Holding companies are normally structured as corporations to protect assets, absorb financial losses and limit liability. Under this model, subsidiaries typically maintain their own individual governing boards with defined authority and reserved powers.

**Operating Company Model:** While the graphic for an operating company model may look similar to the graphic for a holding company model, they are governed and managed in very different ways. Specifically, a much higher degree of centralization of authority exists under an operating company model. Governance often consists of a single parent board that sets policy and directs management activities across the entire organization. Subsidiary operations report solely to the parent CEO or COO.

Sources: smallbusiness.cron.com; businessdictionary.com; The Governance Institute; Kaufman, Hall & Associates, LLC.
**New Metrics**

New success indicators that help executives and boards monitor improved performance are related to better health, care, and access, at lower costs. Metrics include:

- The size of the population an organization covers: as previously defined, measures for three types of covered patient lives are controlled lives, influenced lives and incidental lives
- How well the organization performs in keeping that population healthy and providing accessible, efficient care when needed

Measures indicate whether health/care services of high quality are provided in the least-intensive settings accessible to the patient and at the lowest-possible cost. Identifying and lowering costs will be critical to organizational ability to gain market share and participate in narrow networks. Organizations must use appropriate measures for outcomes, care coordination, patient engagement, efficiency and other factors. One such measurement set is the “Core Metrics for Better Health at Lower Costs,” established by the Institute of Medicine, which appear as Figure 14, page 33 of the Webinar 3 Issue Brief.

During the transitional period, the new measures will need to be used concurrently with traditional volume-based metrics. Metrics appropriate for the leadership team to monitor include:

- Development of the physician platform
- Pricing and competitive cost strategy
- Care coordination and population health management
- Efficiency of service delivery
- Organizational/clinician goal alignment

Figure 7 offers a look at the elements that might be included in an organization’s performance dashboard. Arrows upward or downward indicate positive or negative trends over the previous year.

**FIGURE 7. New Metrics of Leadership Performance and Accountability: Example Dashboard**
At the top left is the number of lives (50,000) covered in value-based arrangements by this fictitious organization. The payer mix indicates that most of these lives are included within a Medicare Advantage plan, with smaller numbers of covered lives from Medicaid and commercial plans. The organization is tracking population by risk level, with three major categories (high, medium and low) encompassing the six categories described in the Webinar 3 Issue Brief, pages 5-6.

The PMPM cost efficiency score is calculated as a ratio of the actual claims costs to the expected claims costs based on the risk score of the patient population served by the provider. Values less than one reflect higher efficiency compared to peers with similar patient-risk scores. Revenue from value-based contracts indicates the organization’s progress toward converting contractual arrangements from volume to value.

Physician measures include data on the percentage of employed physicians that qualifies for electronic health record incentive payments (higher is better), the percentage of referrals that “leak” to out-of-network providers (lower is better) and the use of mid-level providers. When used appropriately, these data can yield more resource- and cost-efficient care.

At the top right is a graph of utilization rates, tracking inpatient admissions, ED visits and physician office visits per 1,000 at the three hospitals. The higher level of physician office visits per 1,000 would be expected under PHM care models that aim to keep patients out of EDs and hospitals.

Clinical outcomes measures include:

- All-cause mortality rate: the measure shown here is a ratio of the observed to the expected based on the population risk
- All-cause readmission: this is a risk-adjusted look at the percentage of patients readmitted to the hospital within a defined duration of the discharge date, which Medicare sets as 30 days
- Hospital-acquired conditions (HACs): this is a key patient safety measure

This health system is doing much better (13.8 percent) than the national average (17.5 percent) for readmission rates.36

The CMS core measures composite includes:

- Quality, safety, access and patient satisfaction measures
- HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems), which assesses patients’ perspectives on hospital care
- Average wait time to primary care provider appointment, which is an important PHM measure, with PHM-focused organizations striving to provide same-day access

“During the transitional period, the new measures (of value-based success) will need to be used concurrently with traditional volume-based metrics.”
**Consumer Centricity.** One area of performance and accountability that deserves highlighting is whether the organization and its leadership put respect for consumers’ time at the center of the value proposition. Consumers have grown to expect that companies in all industries will put substantial degrees of creativity and technology into using consumers’ time efficiently and productively.

Unfortunately, most legacy health care organizations are not known for valuing customers’ time. This reputation does not arise from any lack of respect on the part of health care professionals, but is an inevitable outgrowth of entrenched structures and processes. Large facilities can be challenging to access and navigate. All too common are limited physician office hours, repetitious/unconnected patient paperwork, delayed start times for appointments and procedures, and constrained time for conversations with caregivers, among other inconveniences. In short, legacy health care organizations are often perceived as viewing time from the perspective of their own needs, rather than the needs of their patients.

Leadership of innovative companies have seen the gap between patient expectations and legacy health care services, and they are responding by putting respect for consumers’ time at the center of their value propositions. Urgent care chains and retail pharmacies offer convenient locations and walk-in visits. Telehealth providers offer physician or nurse access, and routine diagnosis from home or nearby kiosks. Apps allow consumers to monitor and transmit their health data, ask clinicians about symptoms, find low-cost providers and schedule appointments.

The decision to compete based on the value of consumers’ time is not a small one. A fundamentally different perspective is needed: one in which each type of consumer interaction is seen through the consumer’s eyes. Access to health care is defined by the consumer’s convenience and not by the organization’s schedule or facilities. Technology is fully used to allow consumers to connect with the health care they need. Hospital leadership teams should develop metrics to track their performance in respecting consumers’ time — for example, percentage of on-time/delayed appointments and time to appointments, among other indicators.

**Transformational Cost Improvement.** The final area of consideration for leadership performance and accountability is progress with strategic cost transformation. As described in the Webinar 2 Issue Brief (pages 19-20), lowering the total cost of care requires a new way of thinking. If significant costs are to be removed from the health care system while improving population health, care quality and access, the structure of the delivery system must be reshaped to be more efficient and effective.

To achieve this goal, hospitals, health systems and other care providers will be required to right-size the set of businesses they own, the services they provide and the distribution of each. Metrics of success related to these goals include the extent to which leadership has:

- Migrated payment contracts for both the hospital business and physician business toward value-based care
- Mapped out the optimal clinical network and taken steps to achieve this network
- Reworked governance and management structures and incentives to support maximization of system performance versus maximization of individual sites
Figure 8 illustrates the difference that can be achieved in reducing the total cost of care through marginal cost improvement versus transformational cost improvement. Over time, only the latter will reduce organizational costs to the level required under, and supported by, value-based payment models.

**FIGURE 8. Transformation Versus Marginal Cost Improvement**

The Credit Implications of Leadership Performance

The three agencies that rate health care debt — Fitch Ratings, Moody's Investors Service and Standard & Poor's — are monitoring leadership performance as a key driver of credit ratings and, specifically, the strength/weakness of boards and management teams.

“Effective governance and strong management enable an organization to reach its full potential while avoiding financial stress,” notes Moody’s Investors Service. The agency considers five broad factors in its rating assessments and examines specific “critical factors” related to each:

1. Board and senior management team leadership capability in stable and stressful times. An example critical factor is leadership with diverse experience both inside and outside the hospital.

2. Oversight and disclosure processes that reduce risk and enhance operational effectiveness. Example critical factors are board-approved policies on investments, debt, liquidity and conflicts of interest.

3. Execution of integrated short- and long-term plans to optimize resource utilization. An example critical factor is use of integrated strategic, capital and financial plans.

4. Commitment to self-assessment and benchmarking to promote ongoing improvement. An example critical factor is benchmarking relative to best practices and strategies across the health care sector.

5. Effective management of government relations in efforts to influence local, state and federal health care policy. An example critical factor is the extent of ties to the state and national hospital associations for access to information about proposed state or federal regulation changes that would have potential impact to hospital operational and financial performance.

Leadership must be well-versed with management performance criteria and tracking its own performance related to these criteria.
The rating agencies also are closely evaluating the impact of new-model strategic plans and investments for value-based care on credit rating. In 2013, Moody’s Investors Service added to its rating process demand measures of unique patients, covered lives and employed physicians; and risk-based payment measures of Medicare readmission rates, all-payer readmission rates and risk-based payment contracts.

In balancing an organization’s transition to value with rating requirements, Fitch Ratings assesses the soundness of an organization’s business strategy by asking management to articulate the benefits of the plan, the key risk factors, the oversight and control “guard rails” for monitoring the plan’s implementation, expected timelines, organizational experience, competitors, and the organization’s financial profile and strength.

James LeBuhn, Senior Director and Healthcare Sector Head at Fitch, says: “Our criteria state that if future performance is expected to track differently than historical results due to significant projected plans, environmental changes or management initiatives, Fitch will examine the detailed assumptions that drive projected results. The move toward value-based care and keeping people healthy infers lower volumes and flat revenue growth. Lower profitability is not equal to a lower rating if Fitch believes that the organization’s strategy enhances its long-term viability. As long as the borrower’s underlying strategic position remains sound, a certain amount of variability of financial performance should not affect the rating. We like the fully integrated delivery-network model for health systems, with employed physicians and insurance capabilities, because controlling the premium dollar will become increasingly important.”

Kevin Holloran, Senior Director and U.S. Public Finance and Analytical Manager for Standard & Poor’s, notes that if an organization is not moving toward value arrangements, the agency would want to know why not. “We do want to see some level of experimenting and practicing in population health management,” says Holloran. “For organizations that are investing a lot in PHM, it’s not going to have a huge impact on credit as long as the investments are measured and strategic. We view this as positive and the right thing to do. At some point, investments need to start producing. We don’t expect V-shaped profitability rebounds; U-shaped rebounds are fine.”

Lisa Goldstein, Associate Managing Director of Moody’s Investors Service, identified the questions with potential credit implications that leadership teams must ask and answer when embarking on the insurance or risk-sharing strategies that will be required of most organizations under the PHM model:

• How will you attain the expertise needed?
• Will you start with a small group, such as hospital employees or direct contracting with a small employer?
• What are the capital requirements (startup, launch, operational and regulatory)?
• What is the chosen structure and its risks (for-profit, not-for-profit, joint venture, etc.)?
• What is the anticipated pace of investment and growth; how long is the runway to launch a product?
• What are the IT needs and costs?
• How will you manage both the financing side and the delivery side of health care when payment incentives are different?
• What is the projected impact on financial performance?
• What is the impact of the initial and ongoing capital requirements on cash reserves?

“Whatever the organization’s position on the risk continuum, we expect that the board and leadership team will have considered these questions,” says Goldstein.
Credit ratings matter. A health care organization’s long-term competitive position today depends substantially on its ability to raise affordable capital in the debt markets. This ability, in turn, is highly dependent on the organization’s credit rating and overall creditworthiness. Boards and executive teams of hospitals and health systems must ensure that the organizations they direct attain and maintain a credit rating that permits the organization to effectively compete in its marketplace.

**PHM Leadership Case Examples**

**Engaging the Clinician Network and Organizing for PHM Leadership: Cedars-Sinai Medical Center**

**Organizational Profile**

Cedars-Sinai Medical Center is an independent, nonprofit academic medical center (AMC) located in West Los Angeles. With approximately 900 licensed beds, 2,100 physicians, 3,000 nurses, and total staff of 11,000, Cedars-Sinai has more than 45,000 admissions, 85,000 ED visits and 660,000 outpatient visits per year.

The organization includes the medical center, Cedars-Sinai Medical Group and Cedars-Sinai Health Associates (an Independent Practice Association). More than 180,000 patients are cared for by the two physician organizations, known collectively as Cedars-Sinai Medical Network.

The nation’s largest AMC, Cedars-Sinai has 60 graduate medical education programs, with more than 350 residents and fellows annually. For 18 years in a row, it has been the winner of the National Research Corporation’s Consumer Choice Award for providing the highest quality medical care in the Los Angeles region.

**Leadership Mindset**

Cedars-Sinai focuses on initiatives to demonstrate outstanding quality of care at more affordable cost, while improving the patient experience across the entire health system — inpatient and outpatient. Reflecting its commitment to move the organization’s contracting arrangements to value-based models, Cedars-Sinai participates in numerous different PHM-oriented arrangements, including:

- The Vivity partnership, which involves one-eighth ownership and risk/gainsharing by Cedars-Sinai in a full-risk commercial HMO contract
- Three Medicare Advantage plans
- Three ACOs (a Medicare Shared Savings Plan, and Anthem Blue Shield and Aetna contracts, one of which is a chronic care health plan)

In total, these contracts/programs cover approximately 70,000 lives. Leadership recognizes there is no “magic threshold” in developing PHM capabilities, but that a larger number of covered lives will help the organization improve performance and obtain buy-in from providers. “Cedars-Sinai has been very successful in past decades,” comments Scott Weingarten, MD, MPH, Senior Vice President and Chief Clinical Transformation Officer. “In a way, that makes things easier because we have resources to invest in population health. But the hard part is convincing some people that we need to change and make adjustments to our business and care models for success in the next decade.”
Engaging the Clinician/Physician Network

To help make the needed change, Cedars-Sinai proactively engages and educates network physicians about clinical and business issues at each step related to value-based care. “We offer many educational sessions each year on topics including new models of care delivery and practice changes occurring at the national and local level,” says Dr. Weingarten.

For example, PHM educational series for clinical chairs and medical staff cover topics such as achieving sustainable growth and alternative payment methodologies under new delivery models. With the Merit-based Incentive Payment System (MIPS) coming to the Medicare program in 2019, physicians who wish to continue to care for their patients in the community will need either to participate in MIPS with its upside potential and its downside potential penalty of up to 9 percent, or in alternative payment models like the ones now underway at Cedars-Sinai, explains Dr. Weingarten. “So we discuss care improvements possible through value-related changes and the measures that will demonstrate high-quality care at efficient costs.”

Using data to highlight performance of each clinician enables the development of a right-sized, high-performing network for PHM contracts. “In one initiative, we’re selecting physicians to participate in a population health risk-based contract based on the value of care they provide, as identified through patient quality, patient experience and clinical efficiency data,” says Dr. Weingarten.

Organizing for PHM Leadership

In some cases, Cedars-Sinai uses a dual reporting structure, with a few executives having responsibility in both the physician network and the hospital network. This allows an enterprise or “system-centric” approach. The dual reporting structure facilitates joint focus on both PHM quality and cost improvements, but also initiatives that would improve care under traditional contracts (for example, length-of-stay reduction efforts). “But developing local clinician champions and leaders for PHM has been and will continue to be critical to our success with PHM,” concludes Dr. Weingarten.
Investing in Community Health: Community Hospital of the Monterey Peninsula

Organizational Profile

Located in coastal Monterey, Calif., Community Hospital of the Monterey Peninsula (CHOMP) is a 501(c)(3) nonprofit health system whose parent is Community Hospital Foundation. CHOMP has approximately 250 staffed beds, 2,000 employees and 400 physicians on the medical staff, and it has 11,000 admissions, 51,000 ED visits and 300,000 outpatient visits each year.

With 78 percent market share in its primary service area, CHOMP draws patients from Monterey Peninsula and broader Monterey County, which has a population of approximately 500,000 (Figure 9). There are competitors in relatively close proximity, with some flow of patients occurring between each other’s service areas primarily through community physician referrals.

FIGURE 9. Service Area of Community Hospital of the Monterey Peninsula

Public payers represent nearly 74 percent of CHOMP’s payer mix, with Medicare at approximately 55 percent, Medi-Cal at 14 percent and other government payers at 5 percent. Commercial payers represent 23 percent of the mix, with self-pay patients and workers’ compensation the remaining 3 percent.

Nearly 50 percent of CHOMP’s patients are aged 65 and older. Government insurance and uninsured individuals paid only 53 cents for every $1 of the cost of care they received, which resulted in a $151 million shortfall. Like virtually every hospital in the U.S., CHOMP has to shift the costs of this uncompensated care to individuals covered by commercial insurance.

CHOMP achieved net operating revenue of $486 million in 2014. After operating expenses of $447 million, CHOMP retained $39 million for improvement of services and facilities. The organization contributed more than $160 million in charity care, recruitment of community doctors, and covering costs not paid by Medicare and other government programs.
A New Leadership Mindset

The commitment of CHOMP’s leadership to a new view of health care is reflected in the mission statement approved by the board in April 2015:

“We believe our community’s greatest resource is the health of its people. Our family of organizations is dedicated to the pursuit of optimal health for all people in Monterey County, from birth to end of life.

We believe the achievement of optimal health requires proactive partnering with physicians and other clinicians, health care and community organizations, and, most importantly, each person we serve. Achieving this goal requires our ongoing commitment to delivering exceptional value-based care that’s:

- Preventive (building and retaining health),
- Restorative (facilitating recovery from illness or injury), and
- Palliative (maximizing well-being when recovery is not possible).

We are dedicated to care that is coordinated across all care settings to meet each person’s own goals and needs.

We believe optimal health on an individual level is possible only when each person actively participates in their own health care. We inspire that participation through personalized information, education and support, provided by a coordinated and compassionate team.”

“Moving from volume to value is a philosophical and cultural shift that we started making four or five years ago,” says President and CEO Steven Packer, MD. “With government payers such a high proportion of our payer mix — which forces us to continue to have to shift patient care costs from government to commercial insurers and employers — we just didn’t believe that our financial model would be sustainable going forward.”

During a June 2011 board retreat, CHOMP’s leadership team presented what Laura Zehm, Vice President and Chief Financial Officer, describes as a George Bailey moment:

“We showed forecasts of what would occur if CHOMP didn’t make an ambitious movement to the community-wide population health management model. It went like this: without an adequate primary care base and inability to bring in new physicians, patients would end up in the emergency rooms. We would continue to lose money on Medicare and Medi-Cal patients. We’d ‘race to the bottom’ on our commercial contract rates, and in effect, we’d be no more than a commodity, i.e., a pricing-taking organization. We’d be unable to invest in the competencies needed for a new care and payment model. We had greater risk to the organization if we did nothing.”

Rather than opt for gradual decline, CHOMP’s leadership team developed a plan of action. CHOMP could disrupt itself through embracing the development of and participation in a new model centered on community peninsula-wide health/wellness. While ambitious, expensive and time-consuming, this model would ensure that the organization could continue:

- Spending more than $160 million a year to ensure care access for those who can’t afford it or whose insurance doesn’t cover it
- Maintaining financial health and an A+ credit rating with a positive outlook
- Growing strategically
- Making care as affordable as possible
The organization’s leaders came to the conclusion that the county is just not a big enough market to do things in any other way than collaboratively with other providers. “We’re not competing with the neighboring hospital nearly as much as is typical of hospitals in larger metropolitan regions,” notes Dr. Packer. “Everyone realizes that we can do much more together than apart.”

“We started with this basic assumption and moved rapidly with the board’s approval into developing capabilities to manage population health and assume risk as an accountable care organization,” says Dr. Packer.

**PHM Governance and Leadership Structure**

One of CHOMP’s first steps was to form a separate subsidiary that would be responsible for leading a collaborative effort to build and manage the clinical side of integrated PHM capabilities county-wide. “This was the ‘brainchild’ of our then-Vice President of Medical Affairs for Community Hospital, Anthony Chavis, MD,” says Zehm. Formed in March 2012 and named Community Health Innovations, LLC, the separate company structure would allow needed distance from the parent health system. This would facilitate a broader range of partnership opportunities and access in the service area.

“The vision was and is to engage organizations that may traditionally have been competitors in the collaborative county-wide effort,” describes Zehm. “The LLC structure enables us to open up ownership and governance of Community Health Innovations to other entities, confirming our commitment to a community-wide entity to better health and reduce costs,” says Dr. Packer. Shared future ownership, for example, could reduce duplication of services across the region, which might occur if multiple hospital systems worked independently to build new ambulatory or other capabilities.

In Dr. Packer’s view, the most pressing governing and leadership challenges for CHOMP and Community Health Innovations are the “Five Ts:” talent, training, technology, trustees and time.

**Talent.** Finding the right executives, managers and staff to engage in population health is exceedingly difficult. Traditional health care management and delivery skill sets are not appropriate. Seeking a top individual who would be “adventurous and somewhat of a risk taker,” CHOMP hired Elizabeth A. Lorenzi in January of 2012 as Vice President and Chief Operating Officer of Community Health Innovations, where she specifically focused on accountable care. Lorenzi brought 25 years of experience as a senior health care executive in Monterey County with strong experience in physician integration and contracting, and building community relations.

“We knew that if we wanted to make meaningful progress in our market with population health, we needed someone who could engage all the players in the community, so we recruited her vigorously,” says Zehm.

**Training.** The knowledge needed to manage population health within specific regions and organizations is still evolving, so the quality and depth of expert resources sought externally were critically important to CHOMP and Community Health Innovations. “Some competencies could be built, but we recognized that we would need to buy and/or partner to obtain other competences,” says Dr. Packer.

For example, Community Health Innovations brought in Geisinger Health System’s xG Health Solutions to provide expert care management training and to equip future case/care managers to operationalize the care management model and navigate in different clinical settings. “You just can’t change the job titles of med/surg or home care nurses, or UR/UM specialists, converting them to care managers,” says Dr. Packer. It takes considerable training. Community Health Innovations nurses go back to Geisinger for immersion weeks in the care management model. Additionally, xG mentors supplement the formal training by accompanying new care management nurses on visits to various sites, including patient homes, hospice facilities and nursing homes.
Technology. The landscape for sharing analytics and clinical information related to care management and population health is still immature and fragmented. Additionally, it is challenging to reconfigure payer data for clinical significance in care monitoring and decision making, comments Dr. Packer. To lead the interconnected/interoperable technology effort, Community Health Innovations hired senior talent with significant health care informatics experience in implementing electronic health records and practice management solutions in ambulatory and acute settings.

Trustees. “Governing boards need to understand that moving from volume to value by nature is like a start-up; red ink is to be expected,” says Dr. Packer. “High visibility and attention to the profit and loss by governance are necessary, but senior executives must feel secure that the board will give them sufficient runway to successfully execute PHM initiatives.” Continuing reinforcement and education are required because many trustees operate successful companies and may be uncomfortable with losses for multiyear periods. But operating quarter-to-quarter would be detrimental to future community health initiatives, notes Dr. Packer.

Time. Highly related to the first four Ts, time is required to develop PHM capabilities community-wide. “The journey from volume to value is not like hitting a switch and suddenly you’re at a point where revenue is coming in to pay for initial and ongoing investments,” says Dr. Packer. And building PHM capabilities is not a part-time endeavor, which is why CHOMP established Community Health Innovations for this function.

“The conversation about our vision, what we want to accomplish and the investment that is needed, must occur frequently and over many years,” says Zehm. “One of the biggest lessons we’ve learned so far is that you just can’t ‘overeducate, or overcommunicate’ with your partners, whether patients, board members, employed/independent physicians, staff, other community hospitals and organizations, health plans, employers or others,” comments Zehm. “Completely changing your identity to one focused on managing population health in partnership with community organizations takes a long time,” says Lorenzi. “It is really, really hard work. But it can be done through successfully involving all of your stakeholders in advancing the process.”

“Completely changing your identity to one focused on managing population health in partnership with community organizations takes a long time. It is really, really hard work. But it can be done through successfully involving all of your stakeholders in advancing the process.” — Elizabeth A. Lorenzi
Agile Development of Innovative Partnerships in Core PHM Areas

A solid commitment to the vision and flexibility enable health care leaders to create solutions that work for the community, while responding to market forces that are constantly changing, comments Lorenzi. Community Health Innovations’ six PHM initiatives, all of which involve partnering with other organizations, are:

- Health information exchange
- Patient-centered medical homes
- Care management and coordination
- Physician alignment and engagement
- Value-based purchasing
- Community wellness, prevention and disease management

These initiatives are interrelated and integrated, as is necessary for successful population health. Space precludes covering each in this paper, but descriptions of example partnerships established by Community Health Innovations for two initiatives follow (Figure 10).

**FIGURE 10.** Integrated Population Management Competencies and Partnership Arrangements

Source: Community Hospital of the Monterey Peninsula. Used with permission.
**Health Information Exchange.** HIE is critical to care coordination across settings in a community. As mentioned in the Webinar 4 Issue Brief, an interoperable health IT ecosystem in a community makes the right data available to the right people at the right time across products and organizations in a way that can be relied upon and meaningfully used by recipients.

For the information framework that would be needed in the community, CHOMP helped to build the HIE in Monterey County, now named Central Coast Health Connect (CCHC). Launched in 2010, it allows health care providers, care managers, health care administrators, health plans and patients to access appropriate patient health information and other clinically integrated data. Data sources include CHOMP and other local hospitals, ambulatory practices, health plans and regional/state registries and HIEs (Figure 11).

**FIGURE 11.** The Health Information Exchange Platform in Monterey County, California

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**“It’s vitally important to data analytics and the care management platform in a community to have enlisted the participation of local hospitals and physicians in a meaningful way,”** says Lorenzi. All of the hospitals in the county agreed to use the same patient portal. Among many other capabilities, through use of CCHC, patients are able to create and review their own health records and communicate with their physicians electronically.

**Monterey Bay Independent Physician Association and Aspire Health Plan.** With the HIE framework in early stages of development, the major initiative in 2012 was building physician alignment and engagement. “Physicians in Monterey and surrounding counties wanted to collaborate to improve community health and didn’t want CHOMP and neighboring health systems to split up the market and make doctors, patients, employers and plans choose among competing accountable care networks,” says Zehm.

With a population of 500,000 people, every single patient would be critical to achieving the scale or network adequacy that would attract payers and other purchasers with value-based arrangements that would improve community health and lower its costs. Because Medicare-age patients constitute such a large proportion of CHOMP’s patient population, development of a commercial Medicare Advantage plan was a key target.
In 2012, however, Monterey County did not have an organized physician organization to provide clinical services in such a plan. Community Health Innovations leadership wanted physicians to decide which model would work best — whether an Independent Physician Association (IPA), clinically integrated network or some type of proprietary model. The last IPA in the area went bankrupt in 1996 and bad feelings remained among some physicians who had been affected.

An extensive number of physician meetings ensued. After dozens of such meetings and reports from designated work groups, strong physician leadership from the whole of the county emerged, supporting a new IPA as the integration model going forward. The Monterey Bay Independent Physician Association (MBIPA) was launched under physician ownership and management in 2013.

“The formation and launch of a new county-wide IPA led by physicians were very purposeful,” comments Lorenzi. Committed to the IPA strategy, CHOMP’s board provided the financial resources required to build consensus and the dollars for the significant legal work involved.

One of the seven strategic intents approved by the board as part of CHOMP’s strategic plan is to be the leader in the development of value-based care models. These models will embrace the concept of integrated population management and use innovative, risk-based, incentive-driven financing models. “We don’t need to invest in a lot of bricks and mortar in the near future,” says Zehm. “Instead, to advance community health, we need to invest in the use of these new models.”

“MBIPA is our broad clinical partner as we increasingly get into risk arrangements,” describes Dr. Packer. MBIPA currently provides Aspire Health Plan the professional services necessary to care for and manage the health of its Medicare Advantage members. Owned by CHOMP, Aspire Health Plan is a Knox Keene-licensed insurance company. The plan signed a CMS Medicare Advantage contract in August 2013 and opened enrollment in October 2013. MBIPA's strong and well-managed network will be essential to the success of Aspire Health Plan.

MBIPA also will be critical to success of the health plan CHOMP has with its own employees and to arrangements with Anthem Blue Cross to manage PPO lives. “Having physician leadership in ACOs to champion care management, disease management and population health is vitally important and perhaps even more important than having physicians in traditional hospital CEO roles,” suggests Dr. Packer.

**Metrics of Leadership Accountability**

Goals for executives responsible for community-wide PHM are focused in the following areas and are based on projected incremental targets:

- Implement CMS’ Chronic Care Management Services CPT 99490 for patients with two or more chronic conditions
- Successfully engage a target percentage of commercially insured patients with two or more chronic conditions and a risk score greater than four managed under an Enhanced Care Coordination (i.e., ACO) agreement with a large commercial carrier
- Achieve appropriate (higher) risk adjustment factor score for Medicare Advantage plan
- Grow Medicare Advantage plan membership
- Grow total lives under any “risk” contract

In the bigger picture, the leadership team of CHOMP and Community Health Innovations measures its progress by how well it applies a PHM approach. They conclude this: “We need to manage utilization; we need to keep people out of the hospital and emergency room when they don’t need to be in the hospital or ED. It’s a lot of blocking and tackling, and being a politician every single day. That’s what really makes the difference.”
A Call to Action

During health care’s complex transformation to a value-based PHM model, leadership must broaden the competencies of executive teams and boards, and make the fundamental changes needed in the organizations’ clinical and business processes, system configuration and the technology platform that supports care delivery.

None of this is possible without a commitment to the inevitability of change and buy-in to the fact that population health management is and should be the direction health care is moving.

Boards and executive teams will have to become “signal seekers,” keeping a close eye on subtle changes in consumer preferences, technology and other factors that may dictate the need for strategic changes. The ability to be sensitive to such subtle signs will be a huge competitive advantage.

Whether a small rural facility or a large urban medical center, California’s hospitals and health systems must have governance and management teams with the knowledge and skills needed to succeed under PHM. This requires proactive learning in all types of forums, from peer-to-peer conversations to formal population health management programs like this one and others.

Governance and management teams must then apply their knowledge to purposefully move their organizations forward toward PHM, by performing without delay the 13 critical tasks outlined on page 37. These tasks, which have been described in the five webinars and Issue Briefs, are not optional.

California currently is at the forefront of the transformation to PHM by virtue of its size, unique demographic profile and historical vanguard role in integrating the delivery and financing of health care services through capitated and other risk arrangements.

“Boards and executive teams will have to become ‘signal seekers,’ keeping a close eye on subtle changes in consumer preferences, technology and other factors that may dictate the need for strategic changes.”
Critical PHM-Related Tasks for Hospital/Health System Leadership and Governance Teams

1. Assess the organization's current position in the market and readiness/ability to participate in PHM.
2. Determine where, when and how the hospital is going to participate in PHM and value-based care delivery.
3. Consider and pursue build, buy and/or partner options based on the organization's objectives, current capabilities, the required timeframe for obtaining the needed capabilities and resource requirements.
4. Ensure the right care in the right place, at lower costs and better quality, thinking broadly about the care patients receive after they leave the hospital's four walls.
5. Invest in and organize infrastructure (bricks and mortar; health information technology, technology) in a way that supports the organization's role and key initiatives in PHM.
6. Build and maintain a high proportion of physicians and other clinicians in executive leadership and governance roles and on executive/board committees, involving clinicians in clinical, business and HIT decision making.
7. Ensure that affiliated physicians and other clinicians are educated about appropriate PHM-focused programs for patient referrals.
8. Quantify the impact of current market trends with positive and negative financial implications.
9. 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.
10. Understand how the organization's single and comprehensive risk profiles stack up to its ability to handle that risk, and make necessary adjustments to balance these components.
11. Start moving contracts to risk-based arrangements to gain critical experience in meeting PHM objectives.
12. Commit to transforming the organization's cost structure through business (re)configuration, service line rationalization, physician alignment and optimization, and other strategies.
13. Create a culture of results and accountability organization-wide.

Sources: Kaufman, Hall & Associates, LLC.
Thank you for participating in the Population Health Management program. We welcome your comments.

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Endnotes

4 Described in the Webinar 1 Issue Brief, pages 10-12.
6 Cleveland Clinic: “Cleveland Clinic HealthSpot to Expand Telehealth Capabilities through Walk-in Kiosks.” Press Release, May 12, 2014.
24 Informal survey conducted by Matthew J. Lambert III, MD, during his more than 10 years leading these sessions offered by the American College of Healthcare Executives.


32 Maestro Strategies (Sept. 2014)

33 For more information, see Fuller, B.P., Grube, M.E., Patel, C.: “Rethinking Governance and Management Structures and Incentive Plans for Value-Based Care,” *Kaufman Hall White paper*, 2012.

34 The Governance Institute (2013)


44 A reference to the movie *It’s a Wonderful Life*.

45 Dr. Chavis is now the Chief Medical Officer for the entire enterprise.

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